

# **EXHIBIT 12**

Aetna Medicare

## SilverScript Choice (PDP)

**Plan type:** Drug plan (Part D)

**Plan ID:** S5601-012-0

[Plan website](#) | **Non-members:** [1-833-526-2445](#) | **Members:** [1-866-235-5660](#)

### What you'll pay

Total monthly premium

**\$33.30**

Retail pharmacy: 2022 estimated total drug costs

**\$9,550.04**

Covers **1 of 2** drugs

### Overview

#### PREMIUMS

**Total monthly premium**

\$33.30

#### DEDUCTIBLES

The amount you must pay each year before your plan starts to pay for covered services or drugs.

**Drug deductible**

\$480.00

**CONTACT INFORMATION**

<b>Plan address</b>	P.O. Box 30016 Pittsburgh, PA 15222
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# Drug Coverage

See if there's help to lower costs for drugs you take.

## PHARMACIES

See the cost level to fill your drugs at the pharmacies you chose. You can also change pharmacies to see the cost level of other pharmacies in your area to find the lowest cost pharmacy.

**CVS PHARMACY #10526**

**Preferred** Preferred in-network pharmacy

## YEARLY DRUG COSTS BY PHARMACY

Drug costs shown vary based on the plan and pharmacy that you use. Contact the plan if you have specific questions about drug costs. [Can my drug costs change by pharmacy?](#)

**Invega 6mg tablet extended release 24 hour**

\$736.44

\$8,813.60

**Total yearly drug cost**

\$9,550.04

## ESTIMATED TOTAL DRUG + PREMIUM COST

	<b>CVS Pharmacy #10526</b> Preferred Preferred in-network pharmacy
<b>Total yearly drug + premium cost</b>	\$9,716.54
<b>When you'll meet your deductible</b>	September 2022
<b><u>When you'll enter the coverage gap</u></b>	You won't enter the coverage gap in 2022

## ESTIMATED TOTAL MONTHLY DRUG COST

	<b>CVS Pharmacy #10526</b> Preferred Preferred in-network pharmacy
<b>August</b>	\$2,160.41
<b>September</b>	\$1,898.64
<b>October</b>	\$1,830.33
<b>November</b>	\$1,830.33
<b>December</b>	\$1,830.33

## ESTIMATED DRUG COSTS DURING COVERAGE PHASES

The drug prices shown may vary based on the plan and pharmacy you've selected. Contact the plan if you have specific questions about drug costs.

## CVS PHARMACY #10526

	Retail cost	Cost before deductible	Cost after deductible	Cost in coverage gap	Cost after coverage gap
<b>Invega 6mg tablet extended release 24 hour</b>	\$397.69	\$397.69	\$67.61	\$99.42	\$19.88
<b>Paliperidone 6mg tablet extended release 24 hour</b> <sup>[1]</sup>	\$1,762.72	\$1,762.72	\$1,762.72	\$1,762.72	\$1,762.72
<b>Monthly totals</b>	\$2,160.41	\$2,160.41	\$1,830.33	\$1,862.14	\$1,782.60

[1]

This plan does not cover this drug, the price shown is the full cash price.

## COSTS BY DRUG TIER

Plans group their drug lists into tiers. The drug costs below show how much you'll pay for drugs in each tier based on the coverage phase you're in.

[Learn more about drug tiers.](#)

<b>Preferred Generic</b>	\$0.00 copay	Generic drugs: 25%  Brand-name drugs: 25%	Generic drugs:  \$3.95 copay or 5% (whichever costs more)  Brand-name drugs: \$9.85 copay or 5% (whichever costs more)
<b>Generic</b>	\$5.00 copay	Generic drugs: 25%  Brand-name drugs: 25%	Generic drugs: \$3.95 copay or 5% (whichever costs more)  Brand-name drugs: \$9.85 copay or 5% (whichever costs more)
<b>Preferred Brand</b>	17%	Generic drugs: 25%  Brand-name drugs: 25%	Generic drugs: \$3.95 copay or 5% (whichever costs more)  Brand-name drugs: \$9.85 copay or 5% (whichever costs more)
<b>Non-Preferred Drug</b>	41%	Generic drugs: 25%  Brand-name drugs: 25%	Generic drugs: \$3.95 copay or 5% (whichever costs more)  Brand-name drugs: \$9.85 copay or 5% (whichever costs more)

		Generic drugs: 25%	Generic drugs: \$3.95 copay or 5% (whichever costs more)
Specialty Tier	25%	Brand-name drugs: 25%	Brand-name drugs: \$9.85 copay or 5% (whichever costs more)

## OTHER DRUG INFORMATION

	Tier	Prior authorization	Quantity limits	Step therapy
<b>Invega 6mg tablet extended release 24 hour</b>	Tier 3	—	<u>Yes</u>	—
<b>Paliperidone 6mg tablet extended release 24 hour</b>	Not covered	—	—	—

## MY DRUG LIST

	Package	Quantity	Frequency	Brand/Generic
<b>Invega 6mg tablet extended release 24 hour</b>		30	Every month	Brand
<b>Paliperidone 6mg tablet extended release 24 hour</b>		60	Every month	Generic

These are drugs you usually get at a doctor's office or hospital outpatient setting, like the flu shot, chemotherapy, or other shots.

<b>Chemotherapy drugs</b>	Not covered	
<b>Other Part B drugs</b>	Not covered	

## Star ratings

**+** Expand All Ratings

### Overall star rating

Overall rating is based on the categories below.



### **+** Drug plan star rating

### Summary rating of drug plan quality

